DOCUMENT RESUME

ED 037 763 CG 005 100

AUTHOR	Vernallis, Francis F.; And Others
TITLE	Saturation Group Psychotherapy in A Weekend Clinic: An Outcome Study. A Goal-Oriented Group Therapy Model for A Saturation Format. Therapists Participation in Saturation Group Therapy.
INSTITUTION	Olive View Hospital, Calif.; San Fernando Valley State Coll., Northridge, Calif.
SPONS AGENCY	National Inst. of Mental Health (DHEW), Bethesda, Md.
PUB DATE	68
NOTE	39p.; Papers were presented at the Western Psychological Association Convention, San Diego, California, June, 1968, and at a conference on "The Role of Transitional Facilities in the Rehabilitation of the Emotionally Disturbed," Kansas State University, Manhattan, Kansas, 1968
EDRS PRICE	EDRS Price MF-$0.25
DESCRIPTORS	*Groups, *Group Therapy, Mental Health, *Mental Health Programs, *Psychological Services, *Psychotherapy, Sensitivity Training

ABSTRACT

Saturation Group Therapy was conducted on a small group of patients for 16 consecutive weekends with 15 hours of group therapy each weekend. The subjects all had recognizable psychiatric problems. Three separate papers are included: (1) the patients' participation, (2) therapists' participation, and (3) a goal-oriented group therapy model for a saturation format. The first paper presents the selection and description of the patient sample, the type of treatment administered to the patients and the control group, the results, and a discussion. The second paper is a study of the therapists during the 16 weeks of treatment. It contains 12 therapist participation categories, definitions of the categories and the procedure used. The third paper is a goal-oriented treatment model which outlines a framework of procedures and participation modes. The treatment process is divided into three sessions. The initial sessions are used to vent feelings, structure treatment, and form a cohesive group. The tactics employed during the central sessions are: (1) to have each patient give an account of himself, and a description of his activities of the previous week, and (2) to have the group closely examine one patient. The final sessions are geared toward synthesis and termination. Also included is a discussion of the treatment model. [Not available in hard copy due to marginal legibility of original document.] (Author/MC)

ED037763

SATURATION GROUP PSYCHOTHERAPY IN A WEEKEND CLINIC: AN OUTCOME STUDY[1,2,3,4]

Francis F. Vernallis

John C. Shipper

Olive View Hospital
Olive View, California

Donald C. Butler
San Fernando Valley State College

T. M. Tomlinson
Office of Economic Opportunity
Washington, D. C.

Saturation Group Therapy (SGT) takes its name from the sheer massive and cumulative amount of treatment that is provided in a relatively brief time period. As was conducted here, the same small group of patients and a professional therapist met for 16 consecutive weekends with about 15 hours of group therapy each weekend.

A number of intensive group therapies or group experiences have formats which are similar to that of SGT; T-group, sensitivity-training, basic encounter group, and marathon group therapy have in common an extended time period for meeting and small group size. SGT most closely resembles the marathon therapy advocated by Bach (1967) except that a marathon, conventionally, meets for a single weekend. Bach was strongly influenced by Stoller (1967) who collaborated with Bach in the development of marathon therapy. Stoller asserted the marathon group represents a radical alteration in the quality of the psychotherapeutic experience. Other therapists (e.g. Gibb & Gibb, 1967; Mintz, 1967; Rogers, 1967) have reported their work in marathon-type groups and have written enthusiastically about their experiences. Rogers wrote recently, "I would like to share with you some of my thinking and puzzlement regarding a potent new cultural development--the intensive group experience. It has, in my judgment, significant implications for our society." Rogers alluded to T-groups and workshops which had extended over three or four weeks, meeting 6 to 8 hours each day.

The SGT format evolved at the Topeka Veterans Administration Hospital where the director (R. G. St. Pierre, M.D.) conceived the weekend hospital (Marlar & Straight, 1965; Vernallis & Reinert, 1964; Vernallis & Reinert, 1966). At Topeka, group decision soon resulted in approximately 15 hours of group therapy each weekend. The Topeka experience indicated a very high research potential for SGT which resulted in this study.

[1]This study was supported in part, by NIMH Grant #14848.

[2]Assistance with statistical analysis was obtained from the Health Sciences Computing Facility, UCLA, sponsored by NIH Grant #FR-3.

[3]We wish to thank Drs. J. Cohen, R. F. Docter, & P. R. A. May for their insightful criticisms and guidance as advisory board members.

[4]Earlier and briefer versions of this paper were presented at the Western Psychological Association Convention, San Diego, 1968, and at a conference on, "The Role of Transitional Facilities in the Rehabilitation of the Emotionally Disturbed," Kansas State University, 1968.

CG005100

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

Significant differences were hypothesized in favor of the SGT patients as compared to control patients on specified measures derived from pilot work and treatment rationale.

Method

A. Subjects

1. Selection of the patient sample. An eligible applicant was male, between the ages of 18 and 59, employed or seriously looking for work, had a recognizable psychiatric problem, and he was able to provide his own transportation. A chronic shortage of referrals existed, so nearly all applicants, many who barely qualified, were accepted. A few patients, however, were excluded because of acute conflict, illiteracy, or a low likelihood of attendance, the latter decided intuitively. Patients with mild problems did not seek SGT since they preferred not to give up 16 weekends.

2. Description of the patient sample. Five groups of patients were treated consecutively which resulted in a total of 46 treatment patients. The characteristics of the patient sample are presented in Table 1.

Table 1

Demographic and Clinical Characteristics
of the Patient Sample
N = 92

Variables	T	C	Mean or N and %
Demographic Variables			
Age	$\bar{x}$ = 30.91	$\bar{x}$ = 34.07	32.49 R = 18-57
Marital status			
Married	24	25	49 (53%)
Single	16	16	32 (35%)
Separated	2	2	4 (4%)
Divorced	4	3	7 (8%)
Source of referral			
Olive View M.H.C. waiting list	21	18	39 (42%)
Public agencies	14	13	27 (29%)
Publicity in public media	5	9	14 (15%)
Private practice	4	5	9 (10%)
Former patients	2	1	3 (4%)
Education	Av.13.37 yrs.	Av.13.59 yrs.	
Social class (Hollingshead system)			
1. Executive, professional	6	3	9 (10%)
2. Managerial and lesser professionals	3	5	8 (9%)
3. Admin., small business, and minor professionals	18	19	37 (40%)
4. Skilled labor	14	17	31 (33%)
5. Unskilled and semi-skilled labor	5	2	7 (8%)
Clinical Features			
Had prior treatment	37	33	70 (76%)
Formerly hospitalized	10	9	19 (21%)
Reported problems with alcohol or drugs	12	15	27 (29%)
Difficulties with the law			12 (13%)
Trial pending		2	
On probation			
Sex offenders	2	3	
Embezzlement		1	
Auto theft	1		
Narcotics	1		
Driver's license revoked	1	1	

No statistically significant differences were found between the treatment and control patients on any of the above compared dimensions. The twelve college students were placed in social class 3. As one way of regarding them, the patients in the study sample can be seen as the Psychiatric "walking wounded" of the middle class.

As for the clinical features of the patient sample, former treatment ranged from a few hypnosis sessions to several years of twice per week expressive therapy. Of the 19 patients with prior hospitalization, three were hospitalized twice and one three times. Reported problems with alcohol or drugs were a low figure since treatment revealed more serious drinking problems than were reported by either the informant or the patient himself at intake. Drinking, however, was not the dominant symptom for the group as a whole. A patient on probation placed special pressure on the treatment program since violation was apt to result in confinement and treatment termination. Due to the very limited public transportation (including that to Olive View), loss of an automobile operators license is a serious restriction in Los Angeles.

Keeping in mind the known unreliability of diagnoses, it is believed information is communicated by diagnostic classification. The therapists diagnosed 28% as neurosis (all severe) and the remainder as psychosis or personality disorder. Following observation of the treatment participation of the patients and analyses of psychometric data, the program director diagnosed 15 patients as neurotic, 10 as neurotic with detectable psychotic or personality disorder features or both, 13 as psychotic, and 8 as disordered personalities.

B. Procedure

1. General statement. When a patient applied for treatment, provided he met the selection criteria, a further judgment was made concerning his fitness for SGT. If judged suitable, the patient was administered a test battery made up of two self-administered tests and two rating scales. A joint interview with the patient was conducted by a pair of investigators following which they independently rated the patient's symptoms. An observer-reporter designated by the patient was then seen (or telephoned) in a joint interview by two investigators who secured information concerning the patient's social adjustment and made independent ratings. One rater was a full-time employee of the Olive View Mental Health Out-Patient Service rather than this program.[5]

   Once 16 patients were tested, they were arranged alphabetically and divided alternately into two groups. A coin toss determined treatment or control status. When a patient dropped out early in treatment he was replaced by the same random selection procedure. The patients were retested with the same test battery at posttreatment and six-months follow-up.

[5]We wish to thank John R. Krachey, M.S.S.W., who served as a rater.

All group therapy sessions were tape recorded and in-treatment change rating scales were administered at four week intervals.

C. Measures

1. Comparison outcome measures taken on both treatment and control patients. Pilot work had disclosed positive changes on the depression scale of the MMPI and objective item by item judgments on Rotter's Incomplete Sentences Blank (ISB). In this study, ISBs were edited for identifying cues, typed, and blind scored according to a standard method.[6] Since symptom reduction and improved social adjustment were critical treatment aims, two scales, the Symptom Rating Scale (SRS) and the Report of Social Adjustment (ROSA), were selected. Both scales are employed widely by the VA Psychiatric Evaluation Staff and the results of the factor analysis of the SRS by Cohen, Gurel, & Stumpf, (1966) was used here. Thus, at the least, the outcome dimensions of feeling well, symptom reduction, and social adjustment were measured. Significant differences favoring SGT patients were specifically predicted on the MMPI D scale, overall scores of the ISB and ROSA, and Factor E (motivation) of the SRS.

2. In-treatment change ratings. The global change rating scale had anchor points at -4 "became a great deal more disturbed," 0 "no change," and +4 "improved a great deal." Peer, therapist, and self-ratings were made.

Treatment

A. Treatment Patients

1. Therapists. The treatment was conducted by four different therapists. Two of the therapists were advanced Clinical Psychology graduate students, one a Psychiatric Social Worker, and one a Ph.D. Clinical Psychologist (the program director) who conducted two groups. The Social Worker and Psychologist were 5 and 15 years past their graduate degrees respectively. While two therapists worked closely with the wives' Social Worker and the program director, one therapist worked independently.

A Psychiatrist provided general administrative and treatment supervision and prescribed medication as needed.

2. Weekend time period. The weekend time period has unique advantages: (a) minimum disruption of work for those working weekdays, (b) only one round trip to the clinic for those traveling long distances, and (c) use of facilities on weekends which would not be otherwise used.

[6] We are deeply grateful to Dr. Barbara Honker, UCLA, for scoring the ISBs.

3. Treatment format. As was conducted in this study, a typical SGT session began at 9:00 A.M. Saturday and ended 5:00 P.M. Sunday. A professional therapist worked and lived with the patients for the entire weekend. Aside from sleeping, eating, and various recreational activities, the balance of the weekend was spent in group therapy. A typical weekend followed this schedule: (Saturday) 9-12 group therapy; 12-1 lunch; 1-3 recreation; 3-5 group therapy; 5-6 dinner; 6-12, or later, group therapy (Sunday) 7-8 breakfast; 8-12 group therapy; 12-1 dinner; 1-3 recreation; 3-5 group therapy.

4. Social casework. The Social Worker offered the wives two one-hour counseling sessions per week although few wives actually attended all sessions. The Social Worker identified strongly with the treatment program and she was quite flexible about her participation schedule. For example, she saw a few of the wives in 2½ hour individual sessions and attended the treatment group from time to time, taking an active part in the meetings. Furthermore, on two occasions, she and the group therapist made house calls.

5. Concommitant treatment. Eighteen (39%) of the treatment patients received individual or group psychotherapy either concurrently with SGT or during the six-months follow-up period or both. The total amount of concommitant psychotherapy was as follows: 6-30 hours 13; 40 hours 4; and 88 hours 1. It was not regarded undesirable for patients to continue in concommitant treatment or enter another treatment following SGT. In some instances, specific recommendations were made to this end and, in others, patients did so on their own initiative. Referred patients were carefully oriented in differences between SGT and conventional treatment, especially with respect to treatment intensity.

6. Tranquilizing drugs. Twenty-one treatment patients were taking tranquilizers at intake, 10 at posttreatment, and 10 at follow-up. Controls: 25 at intake, 16 at posttreatment, and 10 at follow-up.

7. Broad theoretical considerations. The treatment orientation was essentially psychodynamic eclectic with emphasis on the drive-defense paradigm. This was supplemented by client-centered, learning, and group dynamic principles. In terms of process, structuring and expression characterized the early sessions; goal-direction, high tension, and confrontation prevailed in the middle sessions; and acceptance and synthesis were prominent in the concluding sessions.

The posited critical treatment variables were as follows:

* A large amount of concentrated treatment.
It is obvious that approximately 15 hours of group therapy per weekend for 16 consecutive weeks was a great deal of treatment within a brief time period. This format is SGT's most unique feature. Taking an analogy from education, if four class hours per week are needed to master a statistics course but only one-tenth the time is scheduled, then the typical student will learn

very little. So it is here. Personality and behavior change are not easy and 200 treatment hours rather than, say, 20 may be nearer to what is needed for this patient population to effect desired changes.

* High group cohesion.
  A highly cohesive group formed quickly and most patients found the group attractive and valued their membership in it.

* Specificity and concreteness of interaction.
  By the third weekend or so, tension mounted and problems became quite specific and concrete due to the extended exposure of group members to each other. This can be likened to movie-making where limited acting ability can be concealed by shooting short episodes, film editing, etc. However, if the same actor is required to sustain a lengthy performance, his lack of acting ability is glaringly evident, especially to qualified observers. The same was true in SGT: defenses and conflicts were readily apparent as a result of continuous exposure. The group became remarkably sensitive to repetitions in each patient's participation.

* Intense emotional experience.
  Due to the continuous exposure of group members to each other, strong feelings were generated, such as, a desire to flee from the group or anger bordering on physical violence. Near the end of treatment notably warm, friendly, accepting feelings prevailed.

* A favorable setting for confrontation.
  Confrontation typically occurred during "hot-seating," the procedure in which the entire group focuses its attention on one member to assist him in examining himself. However, since the therapist and group members surrendered their weekends and listened attentively for long periods to each other, a patient was far less likely to see confrontation as scape-goating.

* Powerful group influence toward self-understanding and behavior change.
  Defenses and conflicts were pointed out to the patient by the group. At first, a patient often resisted interpretations or accepted them only in an intellectualized or passive manner. Then weekend after weekend, the group focused its considerable social power on each individual patient to accept the interpretations, work through the defenses and conflicts, and integrate new attitudes or behaviors into his personality. The power of the group, derived from its cohesion, was extraordinary.

* Weekday application of weekend learning.
  New insights were progressively acquired each weekend, applied through the week, then carefully checked on succeeding weekends.

* Review of goal-oriented weekday behavior.
  With a large amount of treatment time available, the patient's report of his behavior through the week was carefully reviewed. His report was checked by both his wife's account and observations made by other group members during weekday activities. Weekday socializing among patients and patients' families was encouraged. It is believed these review procedures virtually forestalled acting out behavior which might have been frequent without a goal-directed approach.

* The therapist as an identification model.
  The therapist's behavior was under constant observation; his responsible participation served as a model.

* Training in goal-orientation.
  The requirements of a very demanding goal-oriented treatment program were beneficial in themselves, especially with respect to acquisition of self-discipline, which in many instances, was sorely needed.

* High therapist motivation.
  Knowing the group members intimately, the therapist was inevitably and deeply concerned with their welfare. Should a therapist be indifferent, it soon would be obvious to the group and threaten the group's existence.

B. Control Patients Treatment.

1. Amount and kind of treatment. During the period from pretreatment to follow-up, the control patients were far removed from no treatment status. Thirty-four of the control patients received some form or a combination of treatment forms: 4 visited a physician for tranquilizing drugs alone; 1 took a management (sensitivity-type) course; 5 were in Alcoholics Anonymous; 3 were hospitalized; and the following amounts of psychotherapy were received: 1-10 hours 12; 10-25 hours 7; 26-50 hours 4; 51-75 hours 2; 76-100 hours 2; and one had 104 hours.

Since control patients were free to seek treatment as they chose, a number may have located the available treatment of choice for themselves. Some of the control patients made substantial improvement. As examples, an unemployed withdrawn schizophrenic was administered 6 electroshock treatments while hospitalized seven weeks; he was employed and socializing by posttreatment with parallel improvement in his test scores. Another control patient who was virtually housebound, spent $1,100 for what is called "Territorial Apprehension Treatment," a verbal dyadic method lasting one week. Although the patient was rigidly compensated at follow-up, he was employed, socialized extensively, and felt much better; test scores also reflected his improvement.

Results

A. Data Collection. Posttreatment evaluations with at least the MMPI and ISB were secured in 88 of 92 instances and in 85 of 92 at follow-up. A few ISBs and MMPIs were secured by mail. If an MMPI and ISB were not secured, then neither a ROSA nor SRS were sought. Control patients were paid for their cooperation. Because of Lie scores of 10 or more, three MMPI records were excluded and one ISB because of more than 20 omissions. The short form of the MMPI was used for the first three groups and the long form for the remaining two. For ROSAs, a joint interview on connecting telephones was carried out in the latter part of the study; since the raters had become quite familiar with ROSA administration, it was believed telephone conversations produced the same data as face-to-face interviews.

B. Reliability.

1. Inter-rater agreement. The product-moment correlations on the outcome rating scales between two raters are presented in Table 2. The low r of .58 on factor A of the SRS was partly due to the assignment of a limited range of scores on that factor. In general, the inter-rater agreement was considered satisfactory on the outcome rating scales and the scores of the two raters were averaged to increase reliability. Ten percent of the ratings were performed by one investigator. A comparison of a sample of scores (20 blanks) by two independent scorers of the ISB gave an r of .99.

Table 2

Inter-Rater Agreement on the SRS and ROSA

Measure	n	r
Report of Social Adjustment	217	.89
Symptom Rating Scale	227	
Factor		
A Uncooperativeness		.58
B Depression-anxiety		.81
C Paranoid-hostility		.77
D Deteriorated thinking		.80
E Unmotivated		.78

C. Measures

1. Attendance. A drop-out was defined as treatment termination without the mutual consent of patient and therapist. Ten treatment patients (22%) dropped out. As for the controls, of the 28 patients who entered psychotherapy, 15 (54%) indicated they terminated prematurely.

2. Psychometric comparisons. Table 3 discloses the results of the comparison of treatment and control patients on the four prediction measures from pretreatment to posttreatment.

Table 3

Comparison of Pretreatment to Posttreatment Average Difference Scores of Treatment and Control Patients on Predicted Measures

Measure	df	$\bar{x}_T$	$\bar{x}_C$	t^1
MMPI-Depression Scale	83	6.52	2.55	2.942*
Incomplete Sentences Blank	84	11.53	12.97	-0.35
Report of Social Adjustment	84	1.79	0.06	3.911**
Symptom Rating Scale, Factor E, Unmotivated	84	2.73	0.14	5.06**

*$p < .005$
**$p < .0005$
^{1}one-tail

Three of the four prediction measures were significant at posttreatment. The number of omissions on the ISB strongly influenced the result for that measure since the control patients had significantly more omissions than the treatment patients from pretreatment to posttreatment ($t = 2.07$, $p < .05$).

For the unpredicted measures, Table 4 shows the results. The treatment patients had a rise in K scores which was regarded as desirable, therefore, MMPI difference scores were calculated without K corrections.

Table 4

Comparison of Pretreatment to Posttreatment Average Difference Scores of Treatment and Control Patients on Unpredicted Measures

Measure	df	$\bar{x}_T$	$\bar{x}_C$	t^1
Minnesota Multiphasic Personality Inventory	83			
Scale				
F		3.21	1.62	1.626
K		1.86	0.26	1.974
Hs		3.72	2.57	1.245
Hy		3.77	2.74	0.925
Pd		2.74	2.62	0.128
Mf		0.84	0.83	0.005
Pa		2.35	1.88	0.602
Pt		7.95	2.74	3.208***
Sc		8.14	4.24	2.099*
Ma		0.26	-0.55	0.880
Si		6.49	1.55	2.455**
Es		5.53	1.33	2.008*
Symptom Rating Scale	84			
Factor				
A Cooperation		1.41	0.16	3.261***
B Anxiety-depression		3.06	1.27	3.791****
C Paranoid hostility		0.79	0.21	2.051*
D Disorganized thinking		1.31	0.50	2.810***

*p < .05
**p < .02
***p < .01
****p < .001
[1]two-tail

MMPI profiles are presented in Figures 1 and 2.

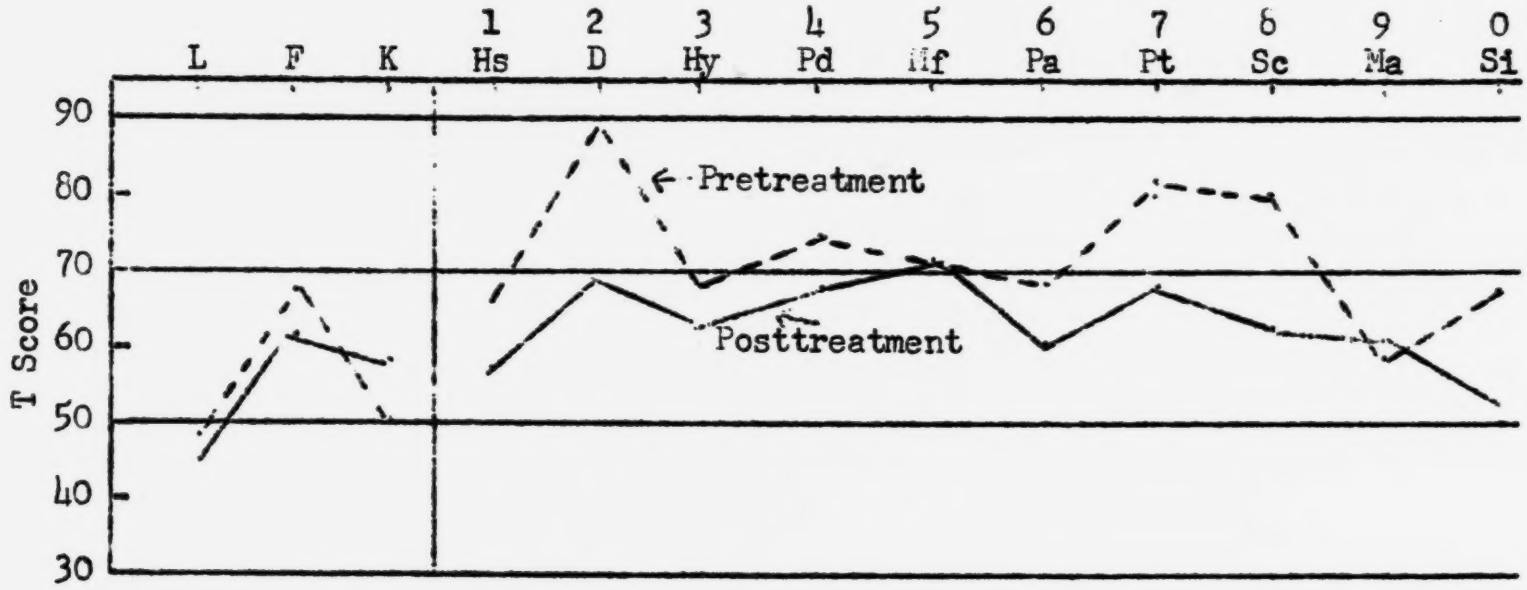

Fig. 1. MMPI profiles for treatment patients which compare pretreatment and posttreatment levels.

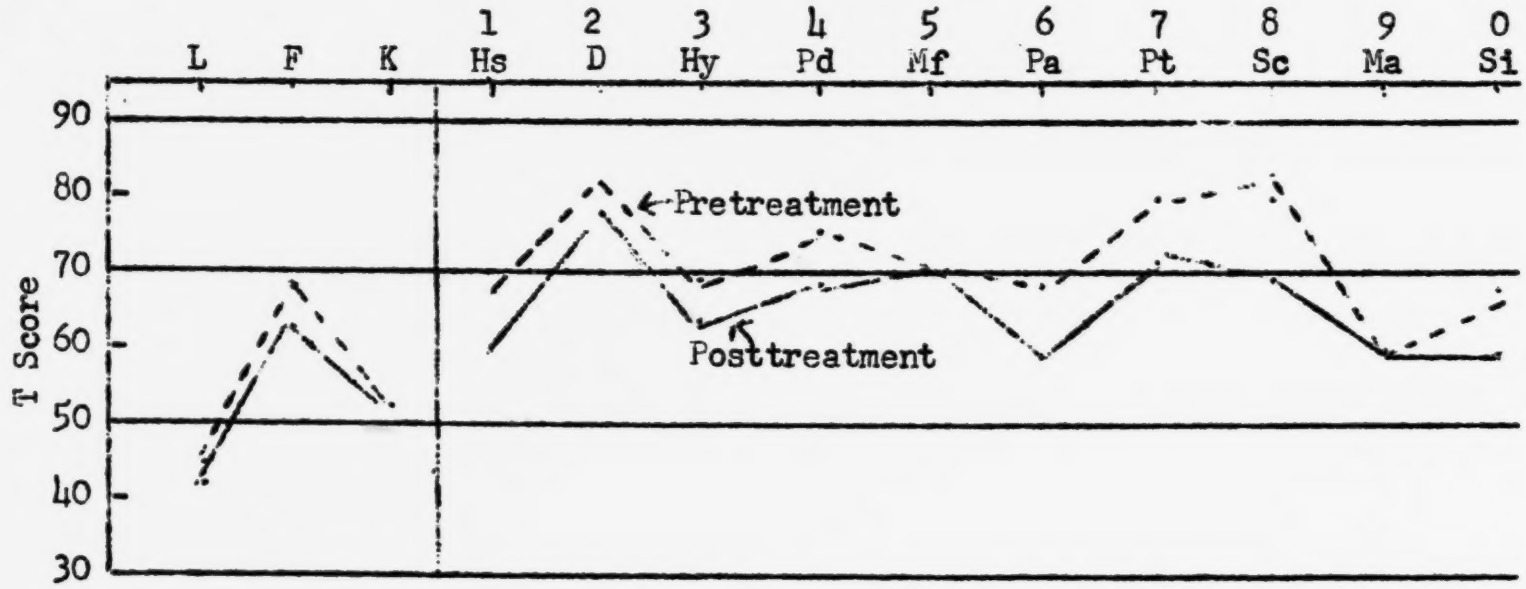

Fig. 2. MMPI profiles for control patients which compare pretreatment and posttreatment levels.

Note that the pretreatment elevation code is 278 which suggests a chronic distressing, rather than situational, type of depression. The ego-strength scores are a minimum estimate since the MMPI short form (where there is less tendency to endorse ego-strength items) was used for two-thirds of the patients.

Comparison of treatment and control groups on change scores from pretreatment to follow-up continued to favor the treatment patients. Most notably, the comparison of the ISB change scores from pretreatment to posttreatment moved from a negative t-score (-0.35) to a positive and significant one from pretreatment to follow-up ($t = 2.02$, $p < .025$). From posttreatment to follow-up, the change scores on the remaining prediction measures also moved in a positive direction; the t-scores for the comparisons between groups were: depression 1.25, goal-direction 1.22, and ROSA .21. A general trend favoring the treatment over the control patients on the unpredicted measures was also found at follow-up.

As an alternative to t-tests based on change scores, an analysis of covariance was performed using pretreatment scores as the covariate. This analysis gave comparable results to those of Table 4. The covariance results were: MMPI D scale ($F = 6.29$, $df = 1/83$, $p < .025$); ISB ($F = .001$, $df = 1/84$, n.s.); ROSA ($F = 23.90$, $df = 1/82$, $p < .001$); goal-direction ($F = 31.70$, $df = 1/83$, $p < .001$). From pretreatment to follow-up the results were: MMPI D scale ($F = 8.05$, $df = 1/80$, $p < .01$); ISB ($F = 3.98$, $df = 1/79$, $p < .05$); ROSA ($F = 14.69$, $df = 1/80$, $p < .001$); goal-direction ($F = 10.05$, $df = 1/75$, $p < .005$). The covariance analysis disclosed initial score differences did not account for the difference between the groups.

The Median Test, a ranking method (Segel, 1956) was used for comparison of the difference scores on the prediction measures from pretreatment to follow-up. The results were: Depression ($X^2 = 6.03$, $df = 1$, $p < .02$); ISB ($X^2 = 1.51$, $df = 1$, n.s.); ROSA ($X^2 = 9.22$, $df = 1$, $p < .01$); goal-direction ($X^2 = 12.46$, $df = 1$, $p < .001$). Except for the ISB, the rank order transformation of the difference scores disclosed that a few extreme cases did not strongly influence the results.

In addition to general social adjustment (work, family-friends, and recreation), specific questions on the ROSA referred to difficulties with alcohol or drugs, money, and with the law. Table 5 shows the treatment patients dealt better with those specific problem areas. Counting overlap in difficulties as one case, 2 of 43 treatment cases and 14 of 41 control cases had serious difficulties during the study period. This difference was statistically significant ($X^2 = 11.83$, $df = 1$, $p < .001$). Paranthetically, there were 19 unemployed experimental patients at pretreatment, 7 at posttreatment, and 5 at follow-up; controls: 14 at pretreatment, 11 at posttreatment, and 9 at follow-up.

Although not a comparison measure, when family members of the treatment group were asked to comment directly on how they felt the patients had changed as a result of SGT, 27 reported that the effects were highly favorable, 12 reported favorable effects, 2 reported neither favorable nor unfavorable results, and 1 felt the change was unfavorable.

Table 5

Comparison of Treatment and Control Patients for Reported Difficulties with Alcohol or Drugs, Handling Money, and the Law

Difficulty	Group	Pre	Post	Follow-up
Alcohol	Treatment	4 serious 7 slight	5 slight	1 serious 6 slight
	Control	7 serious 5 slight	4 serious 6 slight	5 serious 3 slight
Money	Treatment	8 serious 7 slight	1 serious 7 slight	1 serious 5 slight
	Control	11 serious 7 slight	3 serious 6 slight	5 serious 5 slight
Law	Treatment	4 probation 1 drivers' license revoked	1 two traffic tickets	1 one traffic ticket
	Control	1 trial pending (marihuana) 2 probation 1 trial pending (forgery) 2 license revoked	1 homosexual solicitation 1 two traffic tickets 1 disturbing peace	1 drivers' license revoked 1 drunk driving 1 sexually molesting child 1 drunk and disorderly

3. In-treatment change ratings. On the change rating scale at the end of 16 weeks, the therapists mean rating of improvement was 2.18, the self-rating 2.21, and peer rating 1.60, all in the moderately improved interval. The peer rating tally at posttreatment was: became moderately more disturbed: 1; slightly more disturbed: 1; no change: 3; improved slightly: 7; improved moderately: 19; improved considerably: 7. The difference between mean peer ratings of improvement from the 4th to the 16th weekend gave a t of 3.47, $p < .01$ in favor of the latter. Figure 3 shows the in-treatment change ratings at four week intervals. The progressive rated improvement as well as notable agreement on improvement from different viewpoints is shown there.

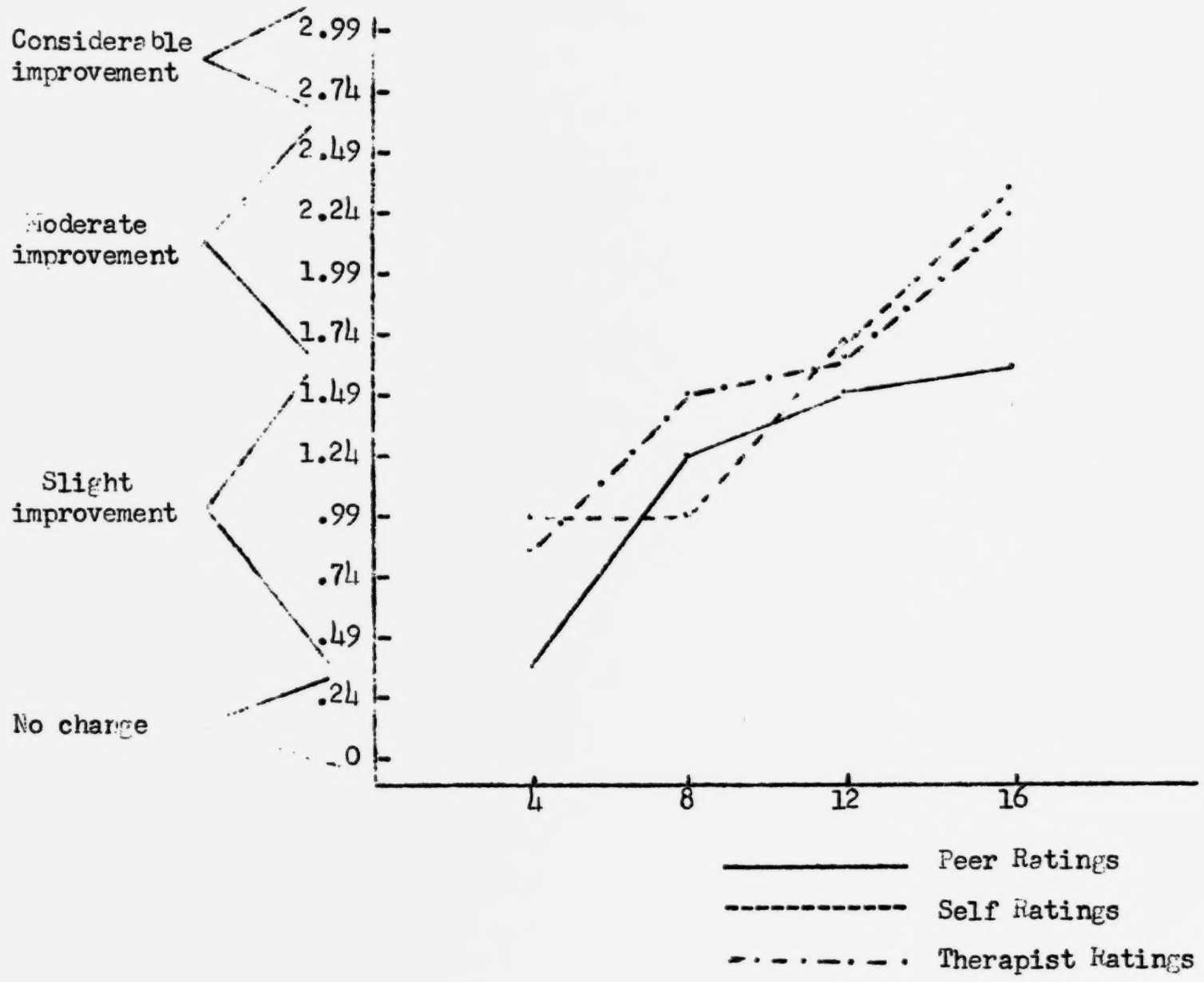

Fig. 3. In-treatment change ratings.

4. Intercorrelations among measures. Calculation of relationships among outcome measures by computer yielded a large number of correlations. Table 6 presents only the intercorrelations among the prediction measures, significant unpredicted measures, and in-treatment change measures at posttreatment.

Table 6

Intercorrelations among Selected Measures at Posttreatment for Treatment Patients

Scale	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Depression		.66	.40	.56	.77	.76	.67	.49	.52	.48	.65	.26	.42	.45
2. Goal-direction			.51	.38	.63	.66	.60	.78	.42	.32	.86	.49	.41	.61
3. ROSA				.30	.23	.25	.25	.42	.36	.23	.42	.44	.18	.44
4. ISB					.52	.56	.63	.38	.37	.24	.44	.24	.18	.31
5. Pt						.94	.69	.53	.62	.66	.63	.25	.31	.37
6. Sc							.74	.61	.63	.64	.70	.29	.28	.34
7. Si								.69	.41	.44	.66	.27	.38	.47
8. SRS A									.48	.48	.79	.19	.38	.39
9. SRS B										.69	.50	.14	.27	.19
10. SRS C											.48	.00	.43	.07
11. SRS D												.47	.52	.64
12. Therapists rating													.10	.53
13. Self rating	.33 < .05 level													.52
14. Peer rating														

The correlations in Table 6 show a high relationship not only among measurement method subscales but also across measurement methods. For example, the self-administered MMPI D scale correlated .62 with goal-direction, a rated variable, or the ROSA (also a rating scale) correlated .51 with goal-direction. The relationship found between self-administered and rating scales suggests the raters did not perform in a notably biased manner. Note that in-treatment change measures correlated with measures external to treatment.

Discussion

Psychometric evidence for the effectiveness of the treatment program was firmly present. The evidence supported the interpretation that SGT resulted in the saturation of the comparison outcome measures in a positive and unequivocal manner. Three of the four prediction measures were significant at post-treatment and all four at follow-up. Consistent with the rationale of the treatment, a large number of unpredicted measures were also statistically significant.

At a minimum, the comparison measures reflected a reduction of discomfort, symptoms, and social dysfunction. The lower MMPI D and Pt scale scores, the lower SRS depression-anxiety scores, and the lower ISB scores all disclosed less personal distress. As for symptom reduction, less disturbed thinking was revealed by the MMPI Sc scale and the disorganized thinking factor of the SRS. The reduction on the paranoid-hostility factor of the SRS denoted less suspiciousness and a more appropriate expression of anger. Increased cooperativeness (SRS factor A) and sociability (MMPI Si scale) further designated a positive movement of symptoms. The ROSA revealed improved work adjustment, better family and social relationships, and more satisfying leisure time activities. And improved motivation toward adaptive goals, a central precondition to social adjustment, was disclosed most specifically by the goalless-apathy or motivation factor of the SRS.

In addition, by an inference farther removed from the test scores, it was inferred that treatment effected a considerable amount of personality change i.e. fewer conflicts in the areas of sex, aggression, dependence, and inferiority. Much of the treatment was aimed at those conflict areas.

A detailed examination of the outcome evidence was carried out since this was an evaluation study. The drop-out rate (22%) was regarded as remarkably low in view of the types of patients treated and the demanding treatment format itself. Recall that 54% of the control patients who entered psychotherapy dropped out. As would be true in industry, the relatively low turnover (drop-out) rate was interpreted as evidence for treatment effectiveness.

The specific items of the ROSA also disclosed better adaptation on the part of treatment patients as compared to controls. Fewer difficulties with drinking, money, and the law were critically important for the individual or those victimized by such behavior. In addition to the specific difficulties, it was learned with respect to violence that one treatment patient and two control patients beat their wives and one control patient assaulted a neighbor. Also, one control patient committed suicide after follow-up. That such a large number of observer/informants saw SGT as highly beneficial also confirmed treatment effectiveness. The in-treatment change ratings by peers, therapists, and self further supported the conclusion that treatment was effective.

The correlational analysis reinforced the interpretation of a positive outcome. The significant r (.44), for example, between peer rated in-treatment improvement and social adjustment, two quite different data sources, substantiated a positive outcome. In fact, whether (a) observer reports (b) investigator ratings (c) self-administered tests or (d) in-treatment change ratings were assessed, the results were consistently positive.

Some clinical descriptions of successful treatment patients, one from each group, may help vivify the results. Don, a 23 year old college drop-out, entered treatment very much a hippie. He was unemployed, passive and withdrawn, had very little sexual interest, wore long hair, and was on marijuana. At the end of treatment, he was employed as a timekeeper, was dating, had a crew-cut, and drank moderately. In the second group, after the conclusion of treatment, Sid, who was originally deeply depressed, unemployed, on probation, and alienated from his wife and four children, left with a job and he possessed remarkable sensitivity as a husbandand father. Sean drank and gambled excessively. He barely held his job as an aircraft industry official and his wife (there were three children) seriously considered divorce. At posttreatment Sean could take a drink or gamble for low stakes or leave them alone and his work and family life were highly satisfying. Derek was sent to Olive View by his wife, an entertainer. She complained he couldn't hold a job, drank too much, and threatened her life via long distance calls to her employers. She declared he was childish and a nuisance. Derek left treatment working steadily and, for the first time in 10 years of marriage and three children, the head of the household. In the last group, Raoul, a Mexican-American, was suspicious and withdrawn. He spent a year in a VA Hospital and was separated from his wife and four children although he had managed to hold a job. At the end of treatment his wife described him as a marvelous person. He was one of the most popular group members, and, from this intimate relationship, inspired some members to Civil Rights activity.

As for failures, only five of the 36 patients who completed SGT failed to improve on psychometric tests and by clinical judgment. Andy was an 18 year old schizophrenic who was locked in a rigid symbiotic relationship with his family. Inspite of intense group pressure to change, Andy's thinking remained incredibly concrete, and he was little affected by treatment. Sterling was a 35 year old divorced man who had had several previous hospitalizations. His affect and thinking remained inappropriate and he continued to be unreflective and unaware of his impact on others. Bill was 30 years old and divorced. Apart from going to work, where he performed in a mechanical manner, he remained in his room, a virtual hermit. His isolation was untouched by treatment. Robin was a 33 year old single unemployed man and a practicing homosexual. Although he participated actively in treatment and despite 88 hours of concommitant psychotherapy, his chronic depression never lifted during the study period. (After follow-up, however, he moved to another city and wrote a letter which stated he was employed, no longer depressed, and that he related to others). Howard was a 22 year old college student. He was a rigidly defended obsessive-compulsive with schizophrenic features. A temporary behavioral change occurred, he moved into a dormitory from his family home for a few months, but his mental symptoms remained largely unchanged.

This study can be viewed from the perspective of more as compared to less treatment. Sixteen consecutive weekends of treatment with approximately 200 hours of group therapy alone is, indeed, a considerable amount of treatment. Other investigators who have systematically studied the dimension of a greater amount of treatment as compared to less have found more treatment more effective. Studies at Johns Hopkins (Imber, Frank, Nash, Stone, & Gliedman, 1957) and in the VA (Lorr, McNair, Michaux, & Raskin, 1962) are well known but there

is a more recent one by Heinecke (1967) who compared one hour per week versus four hours per week of psychoanalytic treatment with children. He was able to show that the four hours per week treatment children enjoyed greater ego-integration, more flexibility, and better school performance.

A trend toward quantitative support for the effectiveness of intensive group treatment appears to be emerging. Having stated that outcome constituted one of the most significant questions of treatment research, Rogers (1967) reported some outcome data. He distributed a follow-up questionnaire and received 481 (82%) returns from individuals who had been in groups which he had organized or conducted. The modal follow-up period was three to six months and results were as follows: less than 1% indicated no change, 14% only temporary positive change, and 57% affirmed a continuing positive improvement. Sinnett (1968) has reported a residential treatment program for college students which shared a number of features with SGT such as maintenance of community functioning, group living, and group therapy (but much less group therapy). Objective evaluation of the program indicated a positive outcome. Systematic studies of T-groups (Miles, 1960; Bunker, 1965) have also disclosed positive results.

Alternative hypotheses can be raised to explain the strongly positive results. A critical alternative is that the principle investigator was biased in favor of SGT which could have induced treatment patients to "fake good" even on the self-administered objective tests. In rebuttal, many other controlled treatment studies very likely had biased investigators yet their quantitative results were often equivocal. However, collaborative disagreement studies are recommended as a possible response to this criticism.

Like most investigators in this field, our main reservation concerns measurement. Test scores did not always resemble the clinical picture. The ISB results for the third and fifth treatment groups at posttreatment highlighted this point. Clinical judgment and nearly all other measures pointed to obvious improvement for the groups yet the ISBs favored the controls. Nonetheless, it is believed a strong treatment effect penetrated the tests on an overall group basis despite some inaccuracy of the tests for individuals and, sometimes, specific groups. Therefore, the measures employed in this study could lead to progress. In his critical review of psychotherapy outcome studies, Cross (1964) concluded productive research is obviously possible even with currently available measures.

The best promise of SGT lies in its research potential. Massive treatment over a short time span could permit the investigation of important variables quickly. Many of the difficulties associated with the maintenance of long-term treatment designs could be eliminated. Replication of results, as in the "hard" sciences, could be done readily.

References

Bach, G. R., Marathon group dynamics: I. Some functions of the professional group facilitator. Psychological Reports, 1967, 20 (3, Pt. 1).

Bunker, D. R., The effect of laboratory education upon individual behavior. In Personal and organizational change through group methods. Schien, E. H., & Bennis, W. G., (eds.) New York: Wiley, 1965.

Cohen, J., Gurel, L., & Stumpf, J. C., Dimensions of psychiatric symptom ratings determined at thirteen time points from hospital admission. Journal of Consulting Psychology, 1966, 30, No. 1, 39-44.

Cross, H. J., Outcome of psychotherapy. Journal of Consulting Psychology, 1964, Vol. 28, No. 5, 413-417.

Gibb, J. R., & Gibb, L. M., Humanistic elements in group growth. In Challenges of humanistic psychology. Bugenthal, J. F. T. (ed.) McGraw-Hill, New York, 1967.

Heinicke, C. M., Frequency of psychotherapeutic session as a factor affecting the outcome and process of child psychotherapy. Paper read at the American Psychological Association Convention, Washington, D. C., 1967.

Imber, S. D., Frank, J. D., Nash, E. H., Stone, A. R., & Gliedman, L. H., Improvement and amount of therapist contact. Journal of Consulting Psychology, 1957, 21, 309-315.

Lorr, M., McNair, D. M., Michaux, W. W., & Raskin, A., Frequency of treatment and change in psychotherapy. Journal of Abnormal and Social Psychology, 1962, 64, 281-292.

Marlar, D. C., & Straight, E. R., Evaluation of the weekend hospital program. Diseases of the Nervous System, 1965, 26, 485-489.

Miles, M. B., Human relations training: process and outcomes. Journal of Counseling Psychology, 1960, Vol. 7, No. 4, 301-306.

Mintz, E., Time-extended marathon groups. Psychotherapy: Theory, Research and Practice, 1967, 4 (2), 65-70.

Rogers, C. R., The process of the basic encounter group. In Challenges of humanistic psychology. Bugenthal, J. F. T. (ed.) New York: McGraw-Hill, 1967.

Siegel, S., Nonparametric statistics. New York: McGraw-Hill, 1956.

Sinnett, E. R., The Kansas State University Rehabilitation Living Unit. Presented at the conference on, "The role of transitional facilities in the rehabilitation of the emotionally disturbed", Kansas State University, 1968.

Stoller, F. H., The long weekend. Psychology Today, 1967, Vol. 1, No. 7, 28-33.

Vernallis, F. F., & Reinert, R. E., The weekend hospital. Mental Hospital, May, 1963, 256-258.

Vernallis, F. F., & Reinert, R. E., Group treatment methods in a weekend hospital. Psychotherapy: Theory, Research, & Practice, May, 1966, Vol. 3, No. 2, 91-93.

A GOAL-ORIENTED GROUP THERAPY MODEL FOR A SATURATION FORMAT

A goal-oriented group treatment model for a saturation format emphasizes the relationship between a particular treatment process and specified outcomes. Massive and cumulative treatment within a relatively brief time period characterizes the saturation format. The treatment process is divided into three periods. The initial period is marked by ventilation, support, and the formation of a highly cohesive group. Several treatment procedures--interpretation and confrontation, "report of the week," "hot-seating," and "going around"--occupy the central sessions; the procedures are coupled with very high tension levels. The final sessions are given to synthesis, termination, and inherent friendliness. Perplexities in the theory are noted.

The following formulation of a goal-oriented group treatment model outlines a framework of procedures and participation modes which are posited as antecedent to specific outcomes. The use of explicit outcome measures places a distinctive rigor on the treatment process. At this stage of the model's development, measurements are taken in the areas of social adjustment, mental symptoms, and personal comfort with personality change inferred from the measures and treatment process. The theory is based on four previous outcome studies (Vernallis & Reinert, 1961; Vernallis, Straight, Cook, & Stimpert, 1965; Vernallis & Reinert, 1966, Vernallis, Shipper, Butler, & Tomlinson, 1969) in which the last two had a Saturation Group Therapy (SGT) format. Although the model is neither notably detailed nor unitary, a position is taken on many treatment variables--goal setting, therapist involvement, modes of support, etc.--and, therefore, it is not theoretically neutral.

The SGT format calls for massive and cumulative treatment within a relatively brief time period. An SGT session is defined as running for most of the weekend with about 15 hours of group psychotherapy meetings and periods for

sleep, meals, and recreation. A meeting is a group therapy meeting. The treatment group is composed of eight to ten patients and a therapist who meet for an unspecified total number of sessions.

Goal-orientation is defined in the same manner as the working definition of "goal-direction" for coders in the study entitled, "Therapist Participation in Saturation Group Therapy," by Vernallis, Shipper, Butler, & Holson (1969). The definition stated:

> "Goal-direction is...any attempt to influence, guide, or control members, especially, by direct request or order. Statements which concern the specific life-goals of productivity, relatedness, and recreation (work, love, and play) are classified in this category. Also coded here are statements which indicate how to engage in treatment. Clarification, reinforcement, or emphasis of treatment goals are also coded here. When a group member is questioned or encouraged to review his efforts (especially during the previous week) toward the achievement of treatment or life goals, these are goal-directed interactions. Encouragement to reduce life goals is also scored here. When goal-direction and another category are equally present in a sentence, priority is given to goal-direction. Examples: The best way to spend your time here is to involve yourself in the group meetings, activities, and group living; How do you see yourself in your dreams, say, in five years?; Tell us about your wife; Let's start here; Let's be honest about this; How did things go for you last week?; As I see it, this is your main problem."

In view of the SGT format, the informal clinical diagnostic categories of severely neurotic, borderline psychotic, and disordered personalities are best suited for goal-oriented treatment. Patients in these categories are apt to be deficient in at least one of the measured outcome areas and, not uncommonly, all three so they are acknowledged patients. The rugged treatment commitment required for the SGT format virtually eliminates people with mild problems i.e. those who are treated more appropriately in an out-patient service. Patients whose reality-ties are quite weak and whose relationship capabilities are destroyed are also ill-suited to the treatment approach.

In view of the types of patients treated, it is posited that a therapist-oriented and patient-centered group process is more effective than a group-centered process. Other features of a goal-oriented treatment model call for a "strong" leadership style i.e. not only appropriate firmness and kindness but also flexibility, tolerance for tension, and risk-taking.

It is assumed that psychodynamic principles--especially the principles of conflicting drives and the resultant tension reduction through defense formation--are generally valid. Group dynamic and learning theory principles are also assumed to be operative.

The treatment process can be divided into initial, central, and final sessions with each division possessing distinct features.

Initial Sessions

Ideally, the early sessions (roughly the first and second) are given to the ventilation of thoughts and feelings, provision of support, structure of treatment, and the formation of a highly cohesive group. The format and certain forms of therapist participa tion promote these ends.

The prolonged sessions facilitate the ventilation of long pent up feel ings; resentments and fears are unloaded freely. This ventilation is encouraged by the therapis t and he accepts the patients' utterances uncritically. It is as though the patients had longed for others to talk to and they finally found in the saturation format a group with whom they could do so. As a part of ventila tion, limited reports of personal histories are encouraged to provide a deterministic view which enables the recognition of maladaptiveness with less guilt. It is assumed that the patient is helped to be less fearful

of losing his defenses if he realizes that in the past he was driven to maladaptive conflict resolutions. And it is also assumed that, at times, the linkage between past and present may be the decisive factor for insight and change.

As another means of support in the early sessions, the therapist's most frequent participation category should be "Giving Information." The working definition for coders was as follows:

> "...a sentence which supplies factual data or expresses an opinion. It includes information given gratuitously as in a lecture or tutoring and it possesses a didactic quality. Simply reporting without inference about past events or current matters is also scored here. Examples: They value self-reliance, a good trait; There's no great kick in it; I haven't seen him; Well, off the top of my head, you know, 'Who's Afraid of Virginia Woolf?,' some fine nun said he's a very compassionate man; You were the baby of the family for some time; This is what the Existentialists say, no one can give you your values."

Also, the therapist should use the giving information category as a means of providing a model for talkativeness. There are many, many hours to be filled in the SGT format so a therapist who remains relatively silent will have an undertalkative and anxious group during the early sessions. However, giving information is not confined to the early sessions alone since it is a frequently employed participation category throughout treatment.

The therapist's presence around the clock, of course, is highly supportive. He provides additional support by individualizing each patient and by forming a strong person-to-person relationship with each group member.

During early therapy meetings, the structuring of treatment, an aspect of goal-orientation, is employed to set the treatment process. The therapist imparts ways to participate, states the rationale of treatment, and he indicates responsible participation on his part. The need for mutual caring, a

critical resporsibility of the group members, is emphasized. Also stated as the responsibility of each member is a readiness to influence others and to be influenced by them. The need to level with each other in an open and honest manner is stressed.

It is postulated that the above set of treatment tactics and the format results in the formation of a highly cohesive group by the end of the initial sessions. Cohesiveness here is the resultant of all the forces acting on all the members to remain in the group. A more as compared to a less cohesive group here is characterized by members who (a) work toward common goals (b) take responsibility for common tasks (c) attend regularly (d) work harder (e) make more sacrifices (f) are more concerned with each each others' welfare (g) are more subject to each others' influence (h) express less discontent (i) like each other more (j) have stronger friendship ties and (k) extol the group's virtues (especially at termination).

Central Sessions

The character of the group therapy meetings changes about the third session when the tension level of the meetings increases. During the central sessions, several different treatment tactics which have considerable tension associated with them are employed to promote treatment goals. The main tactics are (a) interpretation and confrontation (b) "report of the week" (c) "hot-seating" and (d) "going around."

Early in the central sessions, the therapist begins to interpret behavior patterns (not symbols) and confront group members. Repetitions in each patient's account of himself, and, particularly, justifications of his maladaptive behavior are noted and pointed out to him. Due to the continuous

exposure of group members to each other in a virtual hall of mirrors, these repetitions and other problems are seen in a highly specific and concrete manner by the group. Notably, throughout the entire course of the central sessions, interpretation, criticism, and confrontation of each patient's defensive structure is of primary importance and straight talk with earthy language prevails. Denial, rationalization, reaction-formation, intellectualization, etc. are subject to careful examination and strong social influence toward their reduction. The modification of projection, pernaps, best illustrates the process. The acceptance of responsibility for one's own actions becomes virtually a group norm and the externalization of difficulties is censured. This, in turn, improves the patients' interpersonal relationships in the community and, particularly, marital relations.

One of the tactics, "report of the week," is another aspect of goal-direction as defined here. The patients report their activities which occurred during the previous week and the affects associated with behavior patterns are carefully examined by the group. Each patient is urged to make adjustments and improvements in the three areas of productivity, relatedness, and the enjoyment of leisure time. Although treatment goals are proposed to the patients, the details of achieving goals are left to each individual; self-reliance is regularly encouraged and recognized.

Another transaction, "hot-seating," becomes the main mode of group operation. "Hot-seating" is the procedure in which the entire group focuses its attention on one patient for an extended time period. Initially the therapist, then the group members, virtually, cross-examine the center-stage person, firmly rejecting psychopathology. The patient in the hot-seat is questioned about the causes of his problems and inconsistencies between what

he says, does, and feels. In the group, after considerable exposure to each other, motives are manifested in concrete and specific behavior, for it is what the patient does, less than his declared intentions or description of his subjective state or introspections, that reveal his motivation. Much of the content of the interactions consists of sex, aggression, dependent wishes, and feelings of inadequacy with emphasis placed on the recognition and control of these feelings. This hot-seating procedure is regarded as vital, for, unless a patient gains a better understanding of his feelings by looking at himself in relation to his behavior patterns, then positive results on the outcome measures are not apt to occur. During certain stressful periods, a reflective approach is indicated. The desirability of basic self-acceptance and genuine self-esteem is accented. Hot-seating is regarded as the best group tactic for generating strong feeling. This hardy emotional procedure virtually assures strong emotional experiences which, in accord with Frank (1961), are posited as most effective for the correction of long-standing emotional problems. Due to the stress, emotions are experienced directly and the experiential events are followed by their conceptualization; this sequence results in the understanding of emotions and their control. Not only does the patient gain insight but he also learns to take criticism and not to avoid relevant conflict.

Hot-seating is apt to continue for several hours with each person. During hot-seating, the balance of the group listens patiently and attentively and participates in a highly disciplined manner. A peak therapy experience occurs when patients relate dyadically in a sensitive manner for extended periods. Remarks by others not of the dyad are interjected by only one person at a time with the knowledge that the relevance and appropriateness of the remarks will be weighed by the group. These long periods of disciplined listening with only

minimal participation by most members is also highly tension provoking. However, this procedure provides valuable training in listening skill and giving of one's self.

"Going Around" is another important technique for imparting interpretations and resolving conflicts. As in hot-seating, there is one target person in this procedure. The group members, one after another, inform the target person what each sees as the target person's problems. Although not always present, if there is consensus on problems, especially in the context of mutual assistance and high genuine concern for each other, then strong social pressure, indeed, is exerted toward solution. In spite of heroic efforts to reach the target patient, some resist in a life or death manner. Through this experience, the other group members learn the valuable lesson of tolerating their inadequacy feelings and accepting their limitations.

The group remaining together for all activities is another procedure which raises tension since alienated patients fear closeness. Group decision-making further amplifies the tension level in that competing wishes between group members clash sharply over whether to meet on holidays, watch TV, play volley ball, etc.

It may be noted here that although the group is therapist-centered, its decisions are made democratically. Also, with a great deal of treatment time available, all members participate very fully in the treatment process, they know they can take the initiative if they wish, and they learn to respect in a humanistic manner their own worth and the worth of others. Agreement is sought on most issues and the therapist rarely issues direct orders. Group decision-making, of course, teaches the importance of choice and responsibility. The patient shifts from self to group interest, not as self-sacrifice, but in a spirit of give and take.

The high tension level of the group therapy meetings themselves is broken from time to time by casual conversation, humor, and laughter. Also, recreation (particularly vigorous physical activity), small talk during meals, and relaxation during other free periods reduces tension.

The patients' involvement with each other is intense and all through the week they are absorbed with treatment and each other. They think of little else. Rather early during the central sessions, the patients are encouraged to socialize with each other during the week; although they are fully aware of the therapist-led meetings with their norms and values, the weekday socializing gives the patients an opportunity to validate their unique treatment experiences with each other. This too is supportive. Weekday socializing is another source of information for group analysis since it enables the patients to learn about each others' families and home situations directly. Also, this type of socializing provides additional desired control against acting out since the tendency to do so is salient in a highly charged treatment experience. Needless to say, for socially isolated and alienated patients such as these, socializing is a positive and satisfying experience in itself. It is also very likely that socializing generalizes to people external to the group.

The alternation between community living and clinic residence is assumed to be an important feature of the SGT format. New insights or behavior patterns are acquired during treatment sessions, applied in the community, and then carefully checked in succeeding sessions.

It is hypothesized that the above set of treatment tactics and the format result in considerable self-understanding through both interpretation and direct experiencing with consequent personality and behavior change.

Final Sessions

The final sessions, generally the last two, are geared to synthesis, termination, and the friendliness inherent in the treatment process and format. Insights are consolidated and behavior and personality change are reinforced. There is a readiness to terminate. Group members who have gained insights and made attitudinal and behavioral changes are eager to test them on their own. On the other hand, the few who fail to change are eager to terminate too, since they know additional sessions will be aimed at insight and behavior change under high exposure and pressure conditions. However, at this point the group members accept pathology since they recognize in a compassionate manner the intense conflicts which support defenses. Successful patients take pride in their mutual accomplishments which involved hard work, boredom, and frustration, but also excitement, insight, and achievement. All enjoy the idyllically friendly and accepting feelings which characterize the final sessions.

Further Comments

Paradoxes can be seen in the treatment model. For example, there is considerable support and direction while at the same time self-reliance is encouraged. The group process is therapist centered, yet democratic values are promoted. These perplexities, nonetheless, are believed to be consistent with conflicts in living e.g. marriage and career or individuality and conformity. No precise formula for group operation is furnished but, rather, a prescription is stated for presence or absence of certain variables or more or less of certain participation modes.

Learning theory explanations of the treatment process were neglected in the above explication. Learning theory, especially when combined with information theory, may account for the results. Obviously, many things are reinforced in the treatment. However, it is believed a deliberate use of reinforcement schedules would disrupt a very complex social system. Instead, the intuitive alternation of kindness and firmness (not kind-firmness) as advocated by White & Lippett (1960) is employed here. This more closely resembles a coach-player or journeyman-apprentice relationship where there is concern with morale, the relationship itself, etc. It is also recognized that conditioning may explain the treatment process and results. For example, being exposed to the group for lengthy periods, a patient may not be able to hold his "anxiety breath" any longer. He then ventures new behavior and finds it adaptive. Also, a highly cohesive group can be seen as a powerful social reinforcement machine which shapes behavior in a very effective manner.

In sum, given certain types of patients and a therapist who applies goal-oriented group treatment in a saturation format, then the results will be significant on specified measures. The main purpose of the treatment model is to guide the discovery of relationship constancies among crucial variables through experimental test.

References

Frank, J. D., Persuasion and healing: a comparative study of psychotherapy. Johns Hopkins Press, Baltimore, 1961.

Vernallis, F. F., & Reinert, R. E., An evaluation of a goal-directed group psychotherapy with hospitalized patients. Group Psychotherapy, 1961, 14, 5-12.

Vernallis, F. F., Straight, E. M., Cook, A. D., & Stimpert, W. E., The group therapist in the treatment of chronic schizophrenics. Group Psychotherapy, 1965, 4, 241-246.

Vernallis, F. F., & Reinert, R. E., Group treatment methods in a weekend hospital. Psychotherapy: Theory, Research and Practice, 1966, 3, 91-93.

Vernallis, F. F., Shipper, J. C., Butler, D. C., & Tomlinson, T. M., Saturation group psychotherapy in a weekend clinic: an outcome study, (submitted to NIMH).

Vernallis, F. F., Shipper, J. C., Butler, D. C., & Holson, D. G., Therapist participation in saturation group therapy, (submitted to NIMH).

White, R. K., & Lippett, R., Autocracy and democracy: an experimental inquiry. New York: Harper, 1960.

Therapists Participation in Saturation Group Therapy[1]

Francis F. Vernallis John C. Shipper

Olive View Hospital
Olive View, California

Donald C. Butler David G. Holson

San Fernando Valley State College

Saturation Group Therapy (SGT) has as its most distinctive feature a format which calls for massive and cumulative treatment over a relatively brief time period. In the larger project[2] of which this study was a part, the same small group of patients and a professional therapist met for 16 consecutive weekends with about 15 hours of group therapy each week. Applicants who met specified criteria were administered the MMPI, Incomplete Sentences Blank (Rotter), and two rating scales. Patients were then randomly assigned to experimental and control status and five groups of subjects were treated over a three-year period. Four different therapists conducted the five groups. Both treatment and control patients were re-evaluated at posttreatment and six morths follow-up (N = 92). It was concluded SGT resulted in the saturation of the measures in favor of the SGT patients in a clear and unequivocal manner.

The compelling question arose: "What did the therapist do over so many consecutive hours of treatment for 16 weeks?" An answer to the question was the primary purpose of this study.

Method

A. Derivation of the therapists participation categories. Since SGT is eclectic, the therapists 12 participation categories were derived from several theoretical and empirical sources. Giving Information was taken largely from Bales' (1950) "Giving Opinion" and "Gives Orientation" categories. The Questions, Interpretation, Group Laughter, Unscorable, and Mmm categories were taken essentially from Dollard & Auld (1959) and Restatement of Content and Reflection of Feeling from the early Client-Centered approach (Snyder, 1947). The Kindness and Firmness categories were derived largely from White & Lippett (1960) as was Group-Centeredness. Goal-Direction evolved more immediately from our own work (Vernallis & Reinert, 1961) although the explanation of treatment expectancies bore a close resemblance to the approach of others (Goldstein, 1962; Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1964). The 12 categories thus encompass some aspects of psychodynamic, client-centered, learning, and group dynamic principles.

[1]This study was supported in part, by NIMH Grant #14848.

[2]Vernallis, F. F., Shipper, J. C., Butler, D. C., & Tomlinson, T. M., Saturation Group Therapy in a Weekend Clinic: An Outcome Study (in process).

B. Brief definitions of categories.

Giving Information (Gi) is a statement which supplies factual data or expresses an opinion.

Questions (Q) are interrogative utterances and are scored when the therapist asks for information or indicates a lack of knowledge which he wants supplied by a group member.

Interpretation (I) is pointing out patterns or relationships in the material presented of which the patient may not be aware.

Group Laughter (Gl) is the show of mirth or joy with an explosive sound.

Goal-Direction (Gd) is any attempt to influence, guide, or control patients, especially by direct request or order. The structuring of treatment and aspects of reviewing weekday activities are also classed as goal-directed.

Firmness (F) is any deflation of a group member's esteem or status; it connotes a critical, scolding, angry manner of interaction.

Kindness (K) is any raising of a group member's self-esteem or status. Praising, complimenting, reassuring or supporting the patient are all classified as kind responses as are approval and reward.

Unscorable (U) unintelligible remarks and garbled portions of tape recordings are placed here.

Reflection of Feeling (Rf) is putting the patient's feelings in a clearer and more recognizable form from the patient's point of view.

Restatement of Content (Rc) is a repetition by the therapist of the intellectual content of the patient's remarks.

Group-Centeredness (Gc) means the encouragement of cooperation with or subordination to the group. When the therapist refers decisions to the group, those are group-centered sentences.

Mmm (M) indicates mild agreement and that the therapist is listening.

C. Procedure.

1. Sampling. As specified on an a priori basis, the samples for individual patients were taken from tape recordings of the early, middle, and late weekends over the 16 weeks. Within each of these weekend periods, the first sustained interaction in which the patient was the focus of attention for at least 20 minutes constituted the sample for that period. Since some sustained

interactions literally continued for several hours, 5 minute segments at the earliest, intermediate, and last part of the sustained interaction made up the sample. Samples were selected and re-taped for 38 patients. There were 46 treatment patients of whom 10 dropped out, but two drop-outs with 6 and 12 weekends of treatment were retained for this study.

2. Coding. Coders were required to play the tape recorded samples and simultaneously read the accompanying typescripts. The typescripts were then subjected to a unitizing procedure developed by Dollard & Auld (1959) in which the unit is a sentence. Following the unitizing, the therapists' statements were coded into the 12 categories by two coders who worked independently.

Results

A. Inter-coder reliability. The product-moment correlations for category frequencies of 11 of 12 categories by two coders for individual patients ranged from .61 to .96 (mean r = .82); the Gc correlation was only .34. The r was .99 for the total number of units per subject.

B. Category frequencies. The category frequencies of the two coders were averaged to increase reliability. Table 1 presents the category frequencies for each of the five groups.

Note that Gi was the most frequently used category by all therapists.

Table 1

Therapists Category Frequencies

Categories	Gi	Q	I	Gl	Gd	F	K	U	Rf	Rc	Gc	M	Total
Gp. I	339	121	46	33	72	44	18	33	5	8	8	18	745
	46%	16%	6%	4%	10%	6%	2%	4%	1%	1%	1%	2%	21%
Gp.II	305	132	44	22	40	16	39	32	29	45	10	8	722
	42%	18%	6%	3%	6%	2%	5%	4%	4%	6%	1%	1%	20%
Gp. III	330	248	60	50	48	56	22	33	16	31	7	3	904
	37%	27%	7%	6%	5%	6%	2%	4%	2%	3%	1%	0%	25%
Gp. IV	396	130	26	27	64	45	28	22	14	18	3	38	811
	49%	16%	3%	3%	8%	6%	3%	3%	2%	2%	0%	5%	23%
Gp. V	146	114	34	17	28	17	14	13	4	7	2	13	403
	36%	28%	8%	4%	7%	3%	3%	3%	1%	2%	1%	3%	11%
Total	1,516	745	210	149	252	172	121	133	68	109	30	80	3,585
	42%	21%	6%	4%	7%	5%	3%	4%	2%	3%	1%	2%	Units

Discussion

The fact that Information Giving was the most frequent type of participation by all therapists stands out as a finding. However, since receiving information from a professional therapist is experienced as supportive or receiving a "gift" (Lennard & Bernstein, 1960), it is understandable that SGT therapists would resort to this participation mode more than any other. SGT generates a great deal of tension at times since each member is asked to scrutinize himself honestly while under the constant critical eye of group members.

Q, I, and M are standard intervention categories and, therefore, were regularly present in SGT, an eclectic treatment method. Questions transfer the initiative to the other person and SGT therapists, advocates of self-reliance, frequently used this mode. Interpretations, of course, are virtually indispensable in a psychodynamic therapy. The use of M, being socially facilitative, is not unexpected in a treatment with prolonged periods of listening.

Gd, K, and F form a sub-set within SGT since they represent a leadership style. It is believed manipulation of these categories would most likely effect outcome. Gd organizes the treatment experience for the patient and, since SGT stresses improved social functioning, enables close examination and corrective adjustments in weekday living. It is widely recognized that disturbed patients need support at times and an SGT therapist provides a great deal in a variety of ways: his high involvement, minute-by-minute attentiveness, and sheer presence for entire weekends. Nonetheless, an occasional compliment, humorous remark, or reinforcement of effort are specifically scored as K. F must be seen in the context of SGT. Confrontation in measured doses combined with kindness is regarded as constructive and, in the White & Lippett (1960) sense, indicates a "strong" leadership style.

Rf and Rc, of course, are Client-Centered categories. Three of the four therapists had some client-centered training but the low frequencies disclose therapists did not always do what they said they did. Two of the four therapists had stated reflection was an integral part of their treatment approach. However, a Client-Centered attitude may have been present but the coding procedure failed to detect it.

The astonishingly low frequencies in Gc are very likely a matter of sampling. Few group decisions are made during sustained interactions and where there is doubt in coding, Gd is given priority over Gc. One therapist did keep the group together for all activities with the activity choice left to the group.

The remaining categories are miscellaneous ones. Gl discloses the presence of some levity in the group. We are inclined to agree with Dollard & Auld (1959) that a group that laughs together occasionally is apt to work together fairly well. The U frequencies may be low compared to conventional group therapy and, perhaps, reflect the disciplined participation of SGT patients who listened attentively and spoke one at a time.

Bach (1967) employed a questionnaire with patients to determine what they regarded as the most helpful interactions in marathon group therapy. The results supported the hypotheses that advice, aggression-confrontation, and insight mediation were the most helpful. Translated into the present categories, advice appears to resemble Gd, aggression-confrontation resembles F, and insight mediation is similar to I.

The question of how good a guide these therapist participation categories are for student SGT therapists remains open. All four therapists stated their experience was highly unique in comparison to more conventional group therapy but the precise specification of this difference eluded them. Perhaps, application of these categories to the comparison of SGT and conventional group therapy may disclose significant differences in category frequencies. The categories selected here, however, are not viewed as exhaustive and the search for additional ones is regarded as not unlike the search for elements in the periodic table.

References

Bach, G. R., Marathon group dynamics: II. Dimensions of helpfulness: Therapeutic aggression. Psychological Reports, 1967, 20, 1147-1158.

Bales, R. F., Interaction process analysis. Cambridge: Addison Wesley Press, 1950.

Dollard, J., & Auld, F., Jr., Scoring human motives. New Haven: Yale University Press, 1959.

Goldstein, A. P., Therapist-patient expectancies in psychotherapy. New York: Pergamon Press, 1962.

Hoehn-Saric, R., Frank, J. D., Imber, S. D., Nash, E. H., Stone, A. R., & Battle, C. C., Systematic preparation of patients for psychotherapy. I. Effects on therapy behavior and outcome. Journal of Psychiatric Research, 1964, 2, 267-281.

Lennard, H., & Bernstein, A., The anatomy of psychotherapy. New York: Columbia University Press, 1960.

Synder, W. U., Casebook of non-directive counseling. Boston: Houghton Mifflin, 1947.

Vernallis, F. F., & Reinert, R. E., An evaluation of a goal-directed group psychotherapy with hospitalized patients. Group Psychotherapy, 1961, 14, 1-2, 1-6.

White, R. K., & Lippett, R., Autocracy and democracy: An experimental inquiry. New York: Harper, 1960.